



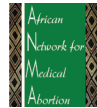
Asia Safe Abortion Partnership



Latin American Consortium
Against Unsafe Abortion



Eastern European Alliance
For Reproductive Choice



African Network
for Medical Abortion

Expanding Access to Medical Abortion: Building on Two Decades of Experience Conference Statement

Conference organised by ICMA in collaboration with Ipas and Gynuity Health Projects and with the help of the Association for Family Planning, Portugal

Six years after the first ICMA conference, “Medical Abortion: An International Forum on Policies, Programmes and Services”, 17-20 October 2004, Johannesburg, South Africa progress has been made toward many of the objectives highlighted at that meeting: misoprostol and mifepristone have been included in the WHO list of essential medicines, mifepristone has been approved in many more countries, and women have access to better information about medical abortion, to name a few. New developments in the area of medical abortion have been highlighted at the 3rd ICMA conference and will drive our future work in the following areas:

Law and policy

- Several countries have either legalized abortion or expanded the legal indications permitted for abortion, and it is critical that we develop and promote guidelines to ensure that women are able to fully exercise their right to a legal abortion.
- Historically, the evidence strongly shows that making abortion legal has been a precondition for eliminating the public health problem of unsafe abortion. Legalisation of abortion also reduces stigma for women, as well as eliminating the legal risks for providers.
- While legal reform remains a priority, in the era of medical abortion, access to safe options for pregnancy termination have become less dependent on the law.

Access to services/service delivery systems

- Over-medicalisation of first trimester abortion imposes barriers to access. Greater efforts to reduce unnecessary medicalisation are needed, affecting law, regulations and service delivery norms. For example, research shows that medical abortion can be provided

safely at primary level by suitably trained nurses, midwives and other mid-level providers, and task-shifting should be implemented to these providers wherever possible in order to improve women’s access to services.

- There is evidence from many countries that the use of medical abortion at home at least up to 63 days of pregnancy is safe, with back up where needed from health services. Some women want more support during the process of medical abortion, however, such as a telephone line to be able to ask questions and get reassurance, and those services should be available for women who want them, especially for young women. Health systems need to respond to women’s needs and provide supportive care.

Access to drugs

- Internet provision of medical abortion pills, including through telemedicine services, has become a reality, and women need information in order to be able to access sources of bona fide, reasonably priced, high quality drugs through this outlet. The Internet and other modern technologies, such as cell phones, can be an important source of information for women, and more work is needed to take advantage of these tools.
- Medical abortion provision has expanded within the private sector and through public-private partnerships in recent years, as well as through pharmacies and other drug sellers. Still, we recognize that it is the responsibility of the public health sector to provide care for all women, and we call on government health systems to guarantee all women access to safe abortion services.
- Low-cost mifepristone and misoprostol products, including combined products, have become available in recent years. We need to work with the pharmaceutical industry and other partners to improve access to high quality medical abortion drugs at affordable prices.

Information needs

- More needs to be known about certain new and existing models for provision of medical abortion, including through social marketing and post-abortion care services. Researchers should study the quality of care that women receive with these, to better understand their experiences and sources of information and to document whether and how these models improve access to safe abortion.
- We recognize the importance of providing accurate information based on the situation and needs of women in the locale and countries concerned, including information designed for low literacy populations. We call on all partners developing informational and advocacy materials to share them freely with other organizations working in this area.
- While providing women information is a critical component of medical abortion, not all women need counseling in order to decide whether to have an abortion or which abortion method they prefer to use. Mandatory counseling or evaluation can be a barrier to access and should be optional and only at the woman’s request.
- Despite the large body of research on women’s experiences with medical abortion in various settings, there are still significant gaps in knowledge, especially related to the experiences of women who obtain medical abortion drugs outside of clinics and never present for clinical care.

Several clinical areas have been neglected and deserve further study, including:

- Pain management
- 2nd trimester abortion in low-resource legally restricted settings
- Post-abortion contraception
- The experience of certain population groups with medical abortion, e.g. adolescents, which may have been documented in several countries but is not widely known.

CLACAI: Update on abortion access in Latin America

According to the World Health Organization, the Latin America and Caribbean region has the highest rate of unsafe abortion in the world: approximately 29 unsafe abortions per 1,000 women of reproductive age. Abortion is legally restricted in almost every country in the region, and it is completely illegal in four countries: Chile, El Salvador and Nicaragua. Where not completely restricted, abortion is often legal in cases of rape and when the pregnancy threatens the woman's health or life.

This year has brought new challenges to the struggle to end unsafe abortion, as well as a few success stories. CLACAI has compiled a few highlights of these developments over the past year.

Of course the biggest success in the region with regard to abortion access is in Mexico City, which recently celebrated the third anniversary of legalized abortion. Around 40,000 women have been served by the public sector legal abortion services in Mexico City since 2007. This year the Mexico City Department of Health opened a new clinic in Iztapalapa, one of the poorest and most densely populated areas of the city, demonstrating a clear commitment to expanding access to communities throughout the metropolis.

While abortion rights have expanded in Mexico City, several other Mexican states have taken steps to restrict access to legal abortion. At least 15 states approved constitutional reforms that protect the rights of the embryo from the moment of fertilization. Various judicial processes are underway to counter these reforms, including attempts to declare them unconstitutional and petitions by over 1000 women claiming violations of their civil rights. Women from 12 states have submitted a complaint to the Inter-American Commission on Human Rights, asking this international body to declare Mexico responsible for violating women's human rights.

For more info:
<http://www.gire.org.mx/contenido.php?informacion=80>
<http://www.tupuedessalvartuvida.org/notas/seguimiento-de-prensa-derecho-a-decidir-y-aborto-mexico.html>

One exciting development in the region is the expansion of telephone support hotlines that offer information about misoprostol. Chile, Ecuador, Peru, Argentina and Mexico are some of the countries that have developed this service, often inspired and sometimes supported by Women on Web. In the majority of cases, these initiatives have been started by organizations of young women, often among university students, with little relationship to the more mainstream women's movement. Their work offers a new way that women can be supported in the use of misoprostol to self-induce abortion.



For more info:
Peru: <http://infoabortoseguro.blogspot.com/>
Chile: <http://abortoinformacionsegura.blogspot.com/>
Ecuador: <http://jovenesdespenalizacionaborto.wordpress.com/>
Argentina: <http://informacionaborto.blogspot.com/2009/10/linea-aborto-mas-informacion-menos.html>

With regard to access to medical abortion drugs, mifepristone is still not available in the region, except in Guyana. As for misoprostol, steps have been taken to make the drug available exclusively in hospitals or otherwise restrict its availability in pharmacies. However, the drug remains available in most countries in the region, with the exception of Brazil. Women access the medication through a variety of outlets, including at pharmacies, from health care professionals and through the black market, and women continue to use the drug to induce abortion as it was first reported in Brazil more than 20 years ago.

For more info:
http://74.54.143.249/~clacai/index.php?option=com_content&view=article&id=648:mapa-misoprostol&catid=5:noticias-&Itemid=7

In some countries, progress has been made to develop protocols for legal abortion within the current normative frameworks. Civil society organizations have played a role in this process by contributing to an appropriate interpretation of the law and introducing a comprehensive and

rights-based approach to those protocols. Peru and Argentina are examples of these initiatives aimed at taking advantage of current norms and guaranteeing access to safe abortion for the indications that are currently permitted. However, full implementation of these public policies has not yet been realized.

For more info:
<http://www.causasalud.org/>
http://www.ipfwhr.org/files/aborto_legal.PDF

Lastly, with regard to legal reform in the region, colleagues in Uruguay are optimistic about the approval of a law which would legalize access to abortion on request up to 12 weeks of pregnancy, similar to the one that was passed in 2008 but was then vetoed by the President. Public opinion polls indicate that 63% are in favor of this legal change, and the Parliament's composition suggests that approval of the law could be feasible. 2011 will be a critical year for making access to legal abortion on request a right for all women.

For more info:
<http://www.mysu.org.uy/>
<http://www.hacelosvaler.org/>

“Abortion Advocacy and HeRWAI” (Human Rights for Women Assessment Instrument Training)



Asia Safe Abortion Partnership (ASAP) in collaboration with Women’s Global Network for Reproductive Rights (WGNRR) and Centre for Reproductive Rights (CRR) conducted a 5 day workshop “Abortion Advocacy and HeRWAI (Human Rights for Women Assessment Instrument Training)” in Hanoi, Vietnam from 25th -29th July 2010.

- Values clarification and sharing strategies for addressing the stigma and marginalization of abortion, both at the societal level and for the individual woman.
- Create a cadre of trained individuals who could be mentors/facilitators for advocates.

It was attended by 23 participants from Malaysia, India, Nepal, Philippines, Mongolia, Iraq, Pakistan, Indonesia, Vietnam, Nepal and Japan. The participants included providers, lawyers, programme managers, activists youth group and NGO representatives.

The specific objectives of the workshop were to:

- Look at the pros and cons of various frameworks for abortion rights e.g. human rights; reproductive justice; public health.
- Find the best practices for linking abortion rights to other social justice and human rights campaigns.
- Investigate ways to improve access despite the law.
- Develop focused abortion related policy analysis and advocacy skills (e.g. use of the Health Rights for Women Assessment Instrument (HeRWAI)).
- Develop strategies for cross regional and international support and collaboration in advocacy efforts, including aimed at international bodies such as the United Nations, the European Court etc.



There were two modules used for the workshop: HeRWAI tool :The Health Rights of Women Assessment Instrument (HeRWAI), developed by the Humanist Committee on Human Rights (HOM), is a human-rights based tool to analyze the impact of a policy on women’s health rights. The purpose of the toolkit was to strengthen the capacity of organizations by providing information and tools



to assist them in their advocacy and/or campaign work to promote innovative policy changes that address local realities and RSHR needs so as to achieve the MDGs in a RSHR-sensitive manner.

Abortion Advocacy Training (AAT) included the International law and developments, Jurisprudence that can be used to shape new laws, Strategies for networking, Lobbying with UN/International and Development of appropriate tools for Advocacy. The purpose of Abortion Advocacy training was to provide a safe space to discuss abortion work and share experiences and effective strategies across regions and contexts.

From the feedback received from all the participants it was clear that the participants found the workshop valuable in terms of content and training. The sessions on ‘MA as advocacy tool’ and ‘Country case studies’ were well appreciated.

All participants worked on country level action plans towards advocacy for improving access to safe abortion.

Asia Safe Abortion Partnership (ASAP) has completed its Legal KAU study

“A Study of Knowledge, Attitudes and Understanding of Legal Professionals about Safe Abortion as a Women’s Right” was conducted by Asia Safe Abortion Partnership (ASAP) in 2008-2009. The study was conducted in 7 countries with local partners: Pakistan (Marie Stopes Society), Nepal (Center for Research on Environment Health and Population Activities - CREHPA), India (Foundation for Research in Health Systems - FRHS), Malaysia (Reproductive Rights Advocacy Alliance Malaysia RRAAM) Sri Lanka (University of Colombo), Philippines (Women LEAD), and Indonesia (Indonesian Planned Parenthood Association (IPPA) and Women’s Health Foundation).

More information on:

<http://www.medicalabortionconsortium.org/news/asap-has-completed-its-legal-kau-study-1210.html>

The Kenya Constitution making process and the war on abortion

Dr Joachim Osur

Senior Advisor at Ipas and ANMA Steering Committee Member

Kenyans overwhelmingly voted in a historic referendum on 4th of August 2010 and approved a new constitution. Two-thirds of the voters approved the document that had generated very heated campaigns. The government backed the document while a few politicians and a section of the church opposed it. The main reason why the church was opposed to the constitution, they said, was that it allowed abortion on demand. They were also unhappy with a clause allowing Muslims to have their courts for solving issues related to divorce and inheritance.

For nearly twenty years, Kenya made several unsuccessful attempts to come up with a new constitution. The worry had been that the existing constitution vested too much power in the presidency and other organs of governance were highly ineffective.

There was wide agreement among Kenyan politicians that the draft constitution which was to be voted at referendum met the objectives for which it was drafted. But the issue of abortion had emerged as a new thing. In the course of consultations, the Church had insisted that the constitution expressly states that life begins at conception and that abortion is not permitted.

The medical fraternity and women's activists warned that putting these clauses in the constitution would be problematic as there was no time to fully discuss them and take into account diverse viewpoints in the society. They advised that it was better to regulate abortion through a negotiated act of parliament. The church however insisted on their position.

Politicians feared that if they went against the will of the church the constitution would not pass. The church has existed as a powerful institution in Kenya and has networks going to the lowest level in the villages. Historically no politician goes against the church in Kenya. Politicians wanted the constitution to pass at referendum and so they supported the inclusion of abortion in the constitution to appease them.

A very intense advocacy by the medical fraternity and women's rights activists followed after that. The advocacy campaign made people realize that it was not possible to outlaw abortion totally as there were medical conditions that called for abortion. Hence, although abortion was included in the constitution, the wording given by the

church was modified to take the medical concerns into account. The final language read as follows:

1. Every person has the right to life.
2. The life of a person begins at conception.
3. A person shall not be deprived of life intentionally, except to the extent authorised by this Constitution or other written law.
4. Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other written law.

The response of the church was that sub-section four of the clause had to be deleted. They said that the clause had been modified to allow abortion on demand and wanted it out. At this point, a very strong feeling was developing in the country that the church was becoming fundamentalist and petty and failed to see the bigger picture of the developments going on in the country. The reality was that without a new constitution, Kenya would slide back into anarchy. The political setting was very fragile. The medical fraternity and women's rights activists also intensified their civic education on women's health, making the population realize the tragedy of unsafe abortion and the importance of not ignoring other sectors of society on the issue.

The church, backed by fundamentalist groups in the United States put up a strong campaign. They joined hands with dissenting politicians who had their own non-religious reason for opposing the constitution to campaign against the constitution. The government also stepped up its campaign for the constitution. For the first time, Kenyan citizens were put in a very difficult situation. They had to make a choice on whether to listen to their church leaders or to politicians.

Among the lessons learned for supporters of women's reproductive health and rights in Kenya were the importance of having a network ready in place that could mobilize for action when abortion surfaced in the constitutional reform process; the need to work effectively with the media so that journalists could report on the issues with good information and understanding; and the need for civil society and those with medical expertise on abortion to provide support to political leaders

who were prepared to be champions but who needed information and support in order to speak out on the issue.

When the referendum came, the people of Kenya took a decision to vote for the new constitution. It was a matter of saving a country from collapse while at the same time appreciating that the contribution of each sector of society is important not only in maternal health but in making a country move forward in harmony.

The happenings in Kenya provide important lessons to countries hoping to review their constitutions in future. The question is whether abortion should be regulated in the constitution. The constitution is the supreme law of a country and only gives a framework for developing other laws. It brings to the fold important principles that should be adhered to in running a country without going into details.

Abortion is however an emotive issue and hard to explain in one sentence. Anti-abortion groups know this and have taken advantage of the principles of constitution making and the fact that constitutions do not go into details of explaining issues. They believe that they can insert one line into the constitution that will totally outlaw abortion. They care less about women's health and hope that other groups will be outsmarted through this strategy. The experience in Kenya however tells a different story. The traditional way is still the best – abortion law should be well negotiated between interest groups and an act of parliament offers the best opportunity for this.

For more information:

<http://reproductiverights.org/en/feature/in-harm%E2%80%99s-way-the-impact-of-kenya%E2%80%99s-restrictive-abortion-law>

The Great Controversy: A Story of Abortion and Constitution Making in Kenya (A forthcoming book by Dr Joachim Osur - currently under review)

ASAP – WoW Misoprostol hotline in Pakistan

Asia Safe Abortion Partnership in collaboration with Women on Waves and Women on Web have launched a hotline in Pakistan in June 2010, that gives information about how women can use the medication misoprostol to have a safe abortion, or to prevent dangerous haemorrhaging after giving birth. Every year 30,000 women die from pregnancy related causes in Pakistan. The use of misoprostol by women themselves after giving birth or for induction of safe abortion can save the lives of 10,000 women in Pakistan every year. Misoprostol is available in Pakistan under the brand names Arthrotec, Cytotec, Cytopan, and ST Mom®.

Women needing information in Pakistan/ hotline numbers:



Flyer for the safe abortion hotline in Pakistan

0307 - 494 07 07 - (Urdu, Punjabi)

0315 - 917 04 08 - (Urdu, Pashto)

0315 - 947 33 99 - (Urdu, Sindhi)

The launch was carried out by the coalition of Pakistani Organization who support women's rights – Aware Girls from Khyber Pukhtoonkwa, Peace Foundation from Sindh and Wake Up Call International from Lahore with the support of Asia Safe Abortion Partnership, Women on Waves and Women on Web. This initiative has been financial supported by Mama Cash. This is the only hotline of its kind in Asia, following the launching of successful hotlines in Latin America. This hotline will put life-saving information directly into the hands of the women who need it.

Pakistan has restrictive abortion laws and a high level of maternal mortality. Abortion is permitted only to save a woman's life, to preserve her health and in cases of rape. Most of the 890,000 abortions performed every year happen outside of the health system, often performed in unsafe conditions. More than 30,000 women die due to complications related to pregnancy. Nearly 90% of women deliver at home in the absence of skilled birth attendants. And only 1 in 20 women reaches emergency obstetric care.

An estimated 11-15% of maternal mortality in Pakistan is caused by unsafe abortions. The taboos around abortion limit access of women to health care services. This results in unsafe abortions, carried out in unhygienic conditions and using dangerous methods. Every year 197,000 women are hospitalized because of complications from unsafe abortions.

More than half of maternal mortality caused by post partum haemorrhage and unsafe abortion can be prevented if women have the right information and access to misoprostol.

Misoprostol can prevent heavy bleeding after giving birth and can be used as a safe and effective way to terminate a pregnancy if taken during the first 9 weeks of pregnancy. Misoprostol can easily be used by women themselves without supervision of health professionals for prevention of postpartum hemorrhage.

It is far safer than the unsafe surgical or traditional methods that women will use when desperately trying to end an unwanted pregnancy and has the same health impact as a spontaneous miscarriage. Usually a miscarriage is handled by women themselves without additional medical supervision.



Women who do need further medical attention because of an incomplete abortion can easily be treated by any doctor. Follow-up treatment for miscarriage and even post abortion care is legal everywhere. Making information about the most effective regimens of misoprostol for prevention of Post partum hemorrhage and for inducing miscarriage easily available to women themselves can save women's lives.

The local groups are using various dissemination strategies to publicize the Hotlines, holding meeting, distributing stickers and flyers. One of the groups did "e-campaigning" and spread the number of Hotline among Organizations and people through e-groups and Face book. Various local groups are helping this campaign by disseminating

information on Misoprostol. They include human rights organizations, grass root NGO's, women's groups, sex worker's groups and lady health workers groups.

Immediately after the Hotline Launch, there has been strong and violent opposition in newspapers and radio from religious groups and political leaders, and threat of reprisals. Besides threats, hotlines have also received calls that condemn the initiative. There may be such increased threats in future with the increased publicity of Hotline. But our local partners are confident to handle these situations.

Following the launch there has been a good response in terms of calls so far, with each helpline receiving an average of 25 calls (including follow up calls) in the month of July. This is the first time data is being collected on such a campaign. ASAP plans to use the findings of this study as an advocate tool to decentralize Medical Abortion in Asian Context.

MEDICAL ABORTION INFORMATION PACKAGE ?

Lack of knowledge about Medical Abortion is widespread, not only among women around the world but also among service providers, policymakers, pharmacists and the lay public. Informing these target groups is a strategic objective of ICMA and the regional networks affiliates.

ICMA Information Package provides comprehensive information on Medical Abortion to address the specific information needs of women, women's groups and organizations and other NGOs, policymakers, and health care providers, particularly those in developing countries. It includes a section containing resources, publications and contacts, model leaflets and examples of educational materials and personal histories. It also includes a section for women who need an abortion.

To access the information package go to: <http://www.medicalabortionconsortium.org>